passed this test.

7. Is an empiric therapeutic trial indicated? This principle should often be combined with questions 5 and 6.

8. Am I allowing a resectable and possibly curable primary bronchial carcinoma to metastasize? Bronchial carcinoma seldom has to be diagnosed within a few days of the first abnormal chest roentogram (except for psychologic emergencies); however, waiting more than four weeks (the time to grow Mycobacterium tuberculosis) is potentially dangerous in primary lung cancer.

9. Am I allowing the patient to develop progressive and possibly irreversible disease while I cannot decide what to do? True disability may become self-perpetuating and psychologically irreversible even after the medical impairment or disease has been corrected.

10. Will the biopsy help the patient? The course of a patient with “end-stage lung disease” or one who is preterminal is seldom improved by a biopsy. After these ten questions are answered and it is determined that a biopsy is still indicated, then I like to look at the following three factors to help me decide which technique to use: (1) the clinical status of the patient, ie, the degree of hypoxia-respiratory failure, anxiety, bleeding diathesis, amount of active airway disease (asthma, bronchitis), and pulmonary hypertension (the latter three categories have an increased morbidity and mortality from all types of invasive procedures); (2) the type of lesion (ie, diffuse vs localized, and if localized, central vs peripheral); and (3) the most likely diagnosis, ie, (a) cancer (resectable for cure: often open biopsy; unresectable for cure: seldom open biopsy), (b) infectious disease (usually sputum and occasionally transbronchial or needle aspiration or biopsy), (c) “specific” pathologic findings (ie, granulomatous, alveolar proteinosis, usually small biopsy, ie, transbronchial), and (d) “nonspecific” pathologic findings or totally unknown (usually open).

With all of these factors in mind, I finally choose the best technique for the properly selected patient. For a more in-depth look at various techniques, the reader is referred to a recent text.

In the article by King et al8 (see page 212), we see that they too are tailoring their procedures to their selected patients: “. . . we have found ourselves doing fewer trephine lung biopsies as other diagnostic techniques . . . prove themselves as valuable diagnostic techniques.” This individualizing is the crux to appropriate use of lung biopsy.

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Pembine: Reflections on Medical Communication

We are living in an age of medical hysteria. It has been said that medical information is evolving so rapidly that a physician could well spend all his waking hours trying to assimilate this information and yet fall rapidly behind. If such is true, we physicians are doomed to mediocrity, and our patients will become the captives of incompetence.

In an effort to stave off the threat of professional obsolescence, the medical community has gone in all directions seeking methods, devices, institutions, vehicles, etc, that will allow the physician to keep up or will subliminally program him to meet the new and dazzling changes in tomorrow’s medical world. Evidence of this frenetic search is manifested in radical changes that have been made in the curricula of medical schools. All sorts of new programmed learning manuals and devices are being produced. We find the American Board of Internal Medicine changing its requirements a number of times in the past five years, trying to find that formula for best educating a specialist. We observe all kinds of electronic devices brimming with canned information that can be plugged into the ears or eyes in the comfort of a soundproof and private booth. Even the drug detail men have supplies of audiocassettes and programmed instruction booklets which are given to physicians free of charge as an indication of that company’s intense interest in continuing medical education. Again in the medical school curricula,

References


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we find evidence of reaction to the mounds of seemingly irrelevant material that was didactically and ploddingly taught in the American medical schools some 15 years ago.

In all of this medical hysteria, there appears to be a common element. That element, I believe, is the depersonalization of medical communication. More to be desired than the firsthand contact with a live teacher is the convenience of the audiovisual tapes, films, and slides. More to be desired than the friendly informal seminar discussion is the sterile inanimate programmed learning manual. We have become so enamored with gimmickry in medical education that we find young medical educators' faces appearing more on television tubes than in classrooms or at the bedside.

What is most astonishing is that once elaborate and sophisticated audiovisual programs have been undertaken, little is done to evaluate the effectiveness of such methods over older and traditional methods of classroom and bedside teaching. Without question, the majority of those people who are involved in such approaches are sincere and well-motivated. Yet from time to time, one has the urge to become impatient and to voice objections and call for reassessment. As in many areas of human endeavor today, we are, no doubt, attempting to assuage our anxieties by using machines as their repositories. We can keep current without gimmickry or gadgetry. This brings me to Pembine.

I suspect there are few readers who know what Pembine is. Therefore, let me explain. Pembine is a small town in northern Wisconsin near the Upper Peninsula of Michigan. About 12 miles from Pembine, deep in the forest on a remote island in the Menominee River, stands an old resort built in 1929 called the Four Seasons Club. There, every weekend after Labor Day since 1944, the Tri-State Therapy Conference has met. It is commonly referred to as the Pembine conference because of the proximity of the small sleepy town. The name, Pembine conference, is entirely unofficial but strikes a more accordant note than does the Tri-State Therapy Conference.

In 1944, chest physicians and surgeons from the states of Minnesota, Wisconsin, and Michigan decided to share their experiences in the diagnosis and treatment of tuberculosis, which at that time was a frightful specter on the medical scene. They wanted the conference to be informal, frank, and open. In order to promote these features, these physicians devised a very interesting and unique way of communicating medical information and experience. They devised a so-called consecutive case presentation, wherein a physician would present 15 or more cases of tuberculosis that he had seen in chronologic order. There was no didactic presentation but only the delineation of the history and the physical, laboratory, and x-ray film findings. The floor was continuously open to criticisms and discussion. This method was obviously an exercise in uncovering mistakes, triumphs, errors, and elation. Since there was no didactic presentation, the discussion could penetrate any seemingly relevant pathway with the upshot being that little that was known about tuberculosis was not touched upon in some fashion at those early meetings. As tuberculosis became less and less of a problem, the Pembine conference directed its attention to other emerging important areas in thoracic disease, such as obstructive pulmonary disease, cancer of the lung, sarcoidosis, diffuse interstitial pulmonary disease, problems of thoracic surgery, and many others, yet retaining the same basic format of the consecutive case presentation with free and open discussion. There are none in attendance who are not participants, for all are expected and encouraged to enter into the foray. Often discussions are heated and controversial, but this aspect serves only to heighten the interest of all participants.

Beyond the method of consecutive case presentation, there are other elements of the Pembine conference which stand out and deserve mention, for they contribute fundamentally to the overall excellence of the meeting. In the first instance, the meeting is small in terms of the number of participants. There are only about 100 who are invited in relative proportions from each of the three states. About one-third of the number are residents in training in either thoracic medicine or surgery. Also present are from four to six outside guest experts who are recognized authorities in the various topics of chest medicine and surgery selected by a committee for a particular Pembine conference. The list of those guest experts who have been at Pembine is a veritable who's who in thoracic medicine and surgery. The Four Seasons Club has recreational facilities, including a nine-hole golf course, tennis courts, miles of lovely wooded hiking trails, and, without question, the best bar in the world. Being 12 miles from nowhere, the participants and guests are literally captives in the woods with nothing more to do than discuss medicine in an intimate and convivial manner in a retreat removed from the hustle and demands of everyday practice.

As I pointed out the element of depersonalization in my previous discussion, so the element at Pembine is personalization—human beings and personalities directly communicating without the intermediary of electronic gimmickry or highly pro-
grammed teaching manuals. You may ask, is it successful? Measurements of success must be somewhat indirect. Without question, it is the best medical meeting that I have ever attended. It is best in the sense of the new medical skills and knowledge I have gained over the years and also in the sense of the far-flung new friendships that have occurred because of Pembine and that have facilitated a continuing medical exchange after Pembine. Its 30 years of continuous endurance stand also as a measure of its success.

If it seems that I am holding Pembine up as a model of medical communication, indeed I am. I would not suggest it as the only model, but I single it out now because I fear, as previously intimated, that we are in the midst of a great deal of tomfoolery regarding medical communication. The fundamental person-to-person, mouth-to-ear, gesture-to-eye forms of human communication have somehow been leached away from our modern concepts. I would not hold to tradition for tradition's sake, but this form of communication has endured because of its effectiveness.

Let me summarize what I believe to be the essence of the Pembine phenomenon. The cornerstone is consecutive real case presentations with free and open discussion by all of the audience. Smallness of the group is another prime feature lending itself to informality and openness. The presence of a goodly number of residents is an absolute necessity. The presence of a small number of renowned experts provides the obvious cross-fertilization and quality control necessary to maintain accuracy and relevance. Lastly, the stage for all of this must be relatively isolated, so that there are no diversions that would unnecessarily break the spell. The pleasantry of Pembine is the cement that binds all into a total learning experience.

It seems that the aging Four Seasons Club is an anachronism in this day of swank resorts with posh accoutrements. As such, it may soon be a thing of the past. It concerns me that when this club is no more, the Pembine conference may be in jeopardy. By saying this, I realize that I am being inconsistent, that I am fearful that all of the elements that I have mentioned previously cannot be effectively brought together in any other setting but Pembine. Intellectually, I am convinced that they can and ought to be; but sentimentally, long after the Four Seasons Club is gone, my senses will instinctively return each weekend after Labor Day to the isolated wooded isle in Wisconsin. I will smell the early morning ground fog scented with pine needles, listen to a mourning dove, and in the evening hear the crackle of fire and laughter ringing in the night. I will say: Wasn’t it grand? Wasn’t it marvelous? Shouldn’t it happen to everyone?

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